Health Policy Commission and Massachusetts Hospital Association

Information Sessions on RBPO/ACO Appeals

July 14, 2016 and July 20, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Introduction to RBPO and ACO Appeals
- Topics of Interest
  - Notice
  - Types of Issues for Appeal
  - Standard of Review
  - Reporting
  - Ongoing Role of OPP
- Stakeholder Input on Best Practices

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Introduction: Appeals Processes for RBPOs and ACOs

Chapter 224 requires the HPC to develop internal appeals and external review processes for RBPOs and ACOs.

Office of Patient Protection (OPP) is directed to establish requirements for DOI-certified Risk Bearing Provider Organizations (RBPO) or HPC-certified Accountable Care Organizations (ACO) to implement appeals processes for reviewing consumer appeals as well as an external review process to obtain third party review of such appeals.

Statutory requirement are comparable to existing consumer protection rules regarding appeals to health plan medical necessity determinations. Appeals process applies to RBPO/ACO provider determinations on referrals, appropriate treatments and timely access to care for patients attributed to the organization.

Introduction: Statutory Requirements

	RBPO	ACO
M.G.L. c. 6D, §15	N/A	(b)(vi) calls for internal appeals plan as required for RBPOs; plan shall be approved by OPP; plan to be included in membership packets
M.G.L. c. 6D, §16	N/A	(a)(8) OPP to establish regs, procedure, rules for appeals re: patient choice, denials of services or quality of care (b) establish external review including expedited review
M.G.L. c. 176O, §24	(a) certified RBPOs shall create internal appeals processes (b) 14 days/3 days for expedited; written decision (b) RBPO shall not prevent patient from seeking outside medical opinion or terminate services while appeal is pending (d) OPP to establish standard and expedited external review process	ACO is to follow M.G.L. c. 176O, §24 when developing internal appeals plan (see M.G.L. c. 6D, §15(b)(vi))

Introduction: Objectives of Interim Guidance

1. Advance consumer protection established in Chapter 224 without duplicating existing rights under carrier insurance appeals
2. Protect patients while recognizing the needs of different providers and minimizing administrative burden and expense
3. Inform consumers about RBPO/ACO providers
4. Build on existing provider mechanisms for addressing complaints
5. Gather and analyze data, to provide foundation for developing appeals processes and rules

Introduction: Overview of Proposed Interim Guidance

Office of Patient Protection Bulletin released on May 6, 2016

- Available at www.mass.gov/hpc/opp
- Sample notice to patient accompanies Bulletin

Requirement to establish an appeals process by September 1, 2016

- Complete process within statutory timeframes
- Provide written notice of decision to patients inclusive of OPP contact information

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Notice

Provide Adequate Notice to Patients

- Make notice available in writing at all locations where patients regularly seek care and include a phone number or other contact information for patients to file an appeal inclusive of OPP contact information
- RBPOs/ACOs can decide best method of notice

Bulletin Applies to Commercial Risk Patients

- Primary care patients for whose care the RBPO or ACO is at risk through an alternative payment contract with a carrier
  - Not including MassHealth patients
  - Not including Medicare patients

Sample, “Notice to Patients,” Accompanies OPP Bulletin

- Sample notice is for guidance
- RBPOs and ACOs are not required to use sample notice

Types of Issues for RBPO and ACO Appeals

Provider Decisions - Access

Referral Restrictions

Type or intensity of treatment or services

Timely access to treatment or services

RBPO/ACO Appeals Process
(M.G.L. c. 176O, § 24)

Carrier Decisions - Coverage

Out of network services

Cost sharing

Medical necessity of treatment or service

Carrier Appeals Process
(M.G.L. c. 176O, §§ 13, 14)

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Case Example – Carrier Appeals Process

Patient Y, her PCP, and her neurologist agree that Patient Y needs a specific kind of treatment for her condition. Patient Y's neurologist submits a prior authorization to Patient Y's carrier to request coverage for the treatment. Patient Y's carrier agrees that Patient Y obtained a proper referral from her PCP and that the neurologist who plans to perform the treatment is in Patient Y's HMO network. However, the carrier determines that the treatment requested is not medically necessary.

Carrier Decisions - Coverage

Medical necessity of treatment or service

Carrier Appeals Process
(M.G.L. c. 176O, §§ 13, 14)

Case Example – RBPO/ACO Appeals Process

Patient Z requires a referral to a neurologist for symptoms that have just developed. Patient Z's PCP is part of an RBPO and refers Patient Z to a neurologist that is affiliated with her RBPO. Patient Z had a neurological condition 5 years ago that was treated by a neurologist affiliated with another provider organization. Patient Z prefers to see this neurologist again due to continuity of care considerations and the possibility that the new symptoms are related to the previous condition. In order to see the specialist, Patient Z needs a referral from her PCP under the terms of her HMO plan and the recommended neurologist is in the HMO network. Patient Z cannot resolve the referral issue with her PCP.

Provider Decisions - Access

Referral Restrictions

RBPO/ACO Appeals Process
(M.G.L. c. 176O, § 24)

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Standard of Review

- Appeals process should give the patient an opportunity to raise concerns about an RBPO/ACO decision or action that affects his or her care
- The review should consider medical necessity and/or considerations of clinical appropriateness, as necessary
- Minimally, the reviewer should have:
  - Clinical background and be in current, active practice
  - Some level of independence from the individual who made the initial decision that the patient is appealing
- RBPOs/ACOs may opt to manage appeals at whichever organizational level is appropriate given their unique business structure and staffing levels

Reporting

RBPOs/ACOs must submit two reports to OPP:

First report is due on December 15, 2016 for complaints received during the period of September 1, 2016 through November 30, 2016.

Second report is due on March 15, 2017 for complaints received during the period of December 1, 2016 through February 28, 2017.

2016 Office of Patient Protection ACO/RBPO Report (Reporting Due 12/15/2016 for Period of 9/1/16-11/30/16)

Submission Element	Regulation Requirements	RBPO / ACO Response
ACO-01	Name of ACO or RBPO	
ACO-02	Provider / Practice Name (if Organization is submitting multiple reports)	
ACO-03	Name and professional title of the general contact person(s) within your organization for patient appeals?	
ACO-03A	Phone Number	
ACO-03B	Email Address	
ACO-04	Copy of Patient Appeals Notice Attached / Sent to OPP (NOTE: The notice need only be submitted once unless it has changed since the previous report.)	
ACO-05	Total Number of Appeals Received by RBPO	
ACO-05A	Number of appeals regarding denials or restrictions on referrals to providers not affiliated with the RBPO	
	Number of appeals in this category resolved in favor of the patient	
	Number of appeals in this category where the initial provider decision was upheld	
ACO-05B	Number of appeals regarding denials or restrictions on type or intensity of treatment or services	
	Number of appeals in this category resolved in favor of the patient	
	Number of appeals in this category where the initial provider decision was upheld	
ACO-05C	Number of appeals regarding denials or restrictions on timely access to treatment or services	
	Number of appeals in this category resolved in favor of the patient	
	Number of appeals in this category where the initial provider decision was upheld	
ACO-05D	Number of "Other" appeals and a description of the issues that consumers raised	
	Number of appeals in this category resolved in favor of the patient	
	Number of appeals in this category where the initial provider decision was upheld	
ACO-06A	Description of ACO/RBPO Appeals Process, including at what organizational level (i.e., individual practice or provider organization) the appeals process is initiated and the standards or guidelines used to review appeals. (NOTE: The second and any subsequent reports need only state any changes to the process since the previous report.)	
ACO-06B	Professional title, and clinical background of the individual(s) reviewing patient appeals. If multiple reviewers or a team of revivers are utilized, please describe this operational approach. (NOTE: The second and any subsequent reports need only state any changes to the operational approach since the previous report.)	

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Ongoing Role of OPP

- Develop FAQ for provider organizations and consumers on RBPO/ACO appeals process
- Create and distribute a template for provider reporting
- Develop protocols and tracking system for OPP staff to manage consumer calls on RBPO/ACO appeals process
  - OPP will educate consumers about the RBPO/ACO appeals process but will not, currently, take a direct role in resolving disputes

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Stakeholder Discussion: Best Practices

One of HPC's objectives in developing the RBPO/ACO appeals process is to build on existing provider mechanisms for addressing complaints.

Please take this opportunity to discuss some of those best practices with the HPC and your fellow provider organizations.

If you have further questions, please contact:

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